STATEMENT OF EMERGENCY

907 KAR 1:065E

(1) This emergency administrative regulation is being promulgated to increase price-based nursing facility service reimbursement to offset a provider assessment in accordance with HB 292 of the 2004 Session of the General Assembly. This action must be enacted on an emergency basis in order to comply with HB 292 of the 2004 Session of the General Assembly.

(2) This emergency administrative regulation shall be replaced by an ordinary administrative regulation filed with the Regulations Compiler.

_____
Ernie Fletcher
Governor

_____
James W. Holsinger, Jr. M.D., Secretary
Cabinet for Health and Family Services

CABINET FOR HEALTH AND FAMILY SERVICES

Department for Medicaid Services

Division of Long Term Care and Community Alternatives

(Emergency Amendment)

907 KAR 1:065E. Payments for price-based nursing facility services.

RELATES TO: 42 C.F.R. Parts 430, 431, 432, 433, 435, 440, 441, 442, 447, 455, 456, 483.10(i), 42 U.S.C. 1396, a, b, c, d, g, n, o, p, r, r-2, r-5

STATUTORY AUTHORITY: KRS 194A.030(2), 194A.050(1), 205.520(3), EO-2004-726, HB 292 of the 2004 Session of the General Assembly

NECESSITY, FUNCTION, AND CONFORMITY: Executive Order 2004-726, effective July 9, 2004, reorganized the Cabinet for Health Services and placed the Department for Medicaid Services and the Medicaid Program under the Cabinet for Health and Family Services. The Cabinet for Health and Family Services, Department for Medicaid Services, has responsibility to administer the Medicaid Program. KRS 205.520(3) authorizes the cabinet, by administrative regulation, to comply with any requirement that may be imposed, or opportunity presented, by federal law for the provision of medical assistance to Kentucky's indigent citizenry. This administrative regulation establishes the method for determining amounts payable by the Medicaid Program for services provided by a price-based nursing facility as well as increases price-based nursing facility service reimbursement in accordance with HB 292 of the 2004 Session of the General Assembly.

Section 1. Definitions. (1) "Ancillary service" means a direct service for which a charge is customarily billed separately from the per diem rate including:

(a) Ancillary services pursuant to 907 KAR 1:023; and

(b) If ordered by a physician:

1. Laboratory procedures; and

2. X-rays.

(2) "Appraisal" means an evaluation of a price-based nursing facility building, excluding equipment and land, conducted by the department in accordance with Section 4 of this administrative regulation for the purpose of calculating the depreciated replacement cost of a price-based nursing facility.

(3) "Appraisal base year" means a year in which the department shall conduct an appraisal of each price-based NF.

(4) "Appraisal period" means a five (5) year period beginning with an appraisal base year. For example, the appraisal period corresponding to appraisal base year 2000 is January 1, 2000 through December 31, 2004.

(5) "Auxiliary building" means a roofed and walled structure:

(a) Serviced by electricity, heating and cooling;

(b) Independent of an NF;

(c) Used for administrative or business purposes related to an NF; and

(d) Constructed on the same tract of ground as an NF.

(6) "Capital rate component" means a calculated per diem amount for an NF based on:

(a) The NF’s appraised depreciated replacement cost;

(b) A value for land;

(c) A value for equipment;

(d) A rate of return;

(e) A risk factor;

(f) The number of calendar days in the NF's cost report year;

(g) The number of licensed NF beds in the NF; and

(h) The NF's bed occupancy percentage.

(7) "Case-mix" means the average price-based NF acuity for Medicaid eligible and dual eligible Medicare and Medicaid residents under a Medicare Part A reimbursed stay in a price-based nursing facility, and is based on Minimum Data Set (MDS) 2.0 data classified through the RUG III, M3 p1, (version 5.12B) thirty-four (34) group model resident classification system.

(8) "Department" means the Department for Medicaid Services or its designee.

(9) "DRI" means an indication of changes in health care cost from year to year developed by Data Resources Incorporated.

(10) "Equipment" means a depreciable tangible asset, other than land or a building, which is used in the provision of care for a resident by an NF staff person.

(11) [~~"Expenditure period" means the period beginning July 1, 2002, and ending June 30, 2004.~~

~~(12)~~] "Governmental entity" means a unit of government for the purposes of 42 U.S.C. 1396b(w)(6)(A).

(12) [~~(13)~~] "Hospital-based NF" means an NF that:

(a) Is separately identifiable as a distinct part of the hospital; and

(b) If separated into multiple but distinct parts of a single hospital are combined under one (1) provider number.

(13) [~~(14)~~] "Land" means a surveyed tract or tracts of ground which share a common boundary:

(a) As recorded in a county government office;

(b) Upon which a building licensed as an NF is constructed; and

(c) Including site preparation and improvements.

(14) [~~(15)~~] "Local unit of government" means a city, county, special purpose district, or other governmental unit in the state.

(15) [~~(16)~~] "Metropolitan Statistical Area" or "MSA" means the designation of urban population centers based on the national census and updated on a yearly basis, as published by the Federal Office of Management and Budget.

(16) [~~(17)~~] "NF" or "nursing facility" means:

(a) A facility:

1. To which the state survey agency has granted an NF license;

2. For which the state survey agency has recommended to the department certification as a Medicaid provider; and

3. To which the department has granted certification for Medicaid participation; or

(b) A hospital swing bed that provides services in accordance with 42 U.S.C. 1395tt and 1396l, if the swing bed is certified to the department as meeting requirements for the provision of swing bed services in accordance with 42 U.S.C. 1396r(b), (c), (d), 42 C.F.R. 447.280 and 482.66.

(17) [~~(18)~~] "NF building" means a roofed and walled structure serviced by electricity,

heating and cooling which is also an NF.

(18) [~~(19)~~] "Nursing facility with a mental retardation specialty" or "NF-MRS" means an NF in which at least fifty-five (55) percent of the patients have demonstrated special needs relating to the diagnosis of mental retardation as determined by the department.

(19) [~~(20)~~] "Nursing facility with Medicaid waiver" or "NF-W" means an NF to which the state survey agency has granted a waiver of the nursing staff requirement.

(20) “Provider assessment” means an assessment imposed by HB 292 of the 2004 Session of the General Assembly.

(21) [~~"Revenue Period" means the period beginning April 2, 2001, and ending June 30, 2004.~~

~~(22)~~] "Routine services" means the services covered by the Medicaid Program pursuant to 42 C.F.R. 483.10(c)(8)(i).

~~(23) "R.S. Means Construction Index" means an indicator of changes in construction costs from year to year developed by the R.S. Means Company, Inc.~~]

(22) [~~(24)~~] "Site improvement" means a depreciable asset element, other than an NF building or auxiliary building, on NF land extending beyond an NF’s foundation if used for NF-related purposes.

(23) [~~(25)~~] "Standard price" means a facility-specific reimbursement that includes a case-mix adjusted component, noncase-mix adjusted component including an allowance to offset a provider assessment, noncapital-facility related component, and capital rate component.

(24) [~~(26)~~] "State survey agency" means the Cabinet for Health Services, Office of Inspector General, Division of Long Term Care.

Section 2. NF Reimbursement Classifications and Criteria.

(1) An NF, a hospital-based NF, or an NF-MRS shall be reimbursed as a price-based NF pursuant to this administrative regulation if:

(a) It provides NF services to an individual who:

1. Is a Medicaid recipient;

2. Meets the NF level of care criteria pursuant to 907 KAR 1:022; and

3. Occupies a Medicaid-certified bed; and

(b)1. It has more than ten (10) NF beds and the greater of:

a. Ten (10) of its Medicaid-certified beds participate in the Medicare Program; or

b. Twenty (20) percent of its Medicaid certified beds participate in the Medicare Program; or

2. It has less than ten (10) NF beds and all of its NF beds participate in the Medicare Program.

(2) An NF-W shall be reimbursed as a price-based NF pursuant to this administrative regulation if it meets the criteria established in subsection (1)(a) of this section.

(3) The following shall not be reimbursed as a price-based NF and shall be reimbursed pursuant to 907 KAR 1:025:

(a) An NF with a certified brain injury unit;

(b) An NF with a distinct part ventilator unit;

(c) An NF designated as an institution for mental disease;

(d) A dually-licensed pediatric facility; or

(e) An intermediate care facility for an individual with mental retardation or developmental disability.

Section 3. Swing Bed and Critical Access Hospital NF Bed Reimbursement.

(1) The reimbursement rate for a federally-defined swing bed shall be:

(a) The average rate per patient day paid to freestanding price-based NF's for routine services furnished during the preceding calendar year, excluding any payment made pursuant to Section 14 [~~15~~] of this administrative regulation; and

(b) Established effective January 1 of each year.

(2) Skilled nursing facility beds in a critical access hospital shall be reimbursed pursuant to subsection (1) of this section if the critical access hospital:

(a) Has no more than twenty-five (25) skilled nursing facility beds; and

(b) Has no more than fifteen (15) acute care patients in the skilled nursing facility beds.

Section 4. Price-based NF Appraisal.

(1) The department shall appraise a price-based NF to determine the facility specific capital component [~~each appraisal base year, which shall be each fifth year beginning with 2000,~~] in order to calculate the NF's depreciated replacement cost.

(2) The department shall not appraise equipment or land. A provider shall be given the following values for land and equipment:

(a) Ten (10) percent of an NF's average licensed bed value for land; and

(b) $2,000 per licensed NF bed for equipment.

(3) The department shall utilize the following variables and fields of the nursing home or convalescent center (#503) model of the E.H. Boeckh Commercial Building Valuation System to appraise an NF identified in Section 2(1) of this administrative regulation:

(a) Provider number;

(b) Property owner - NF name;

(c) Address;

(d) Zip code;

(e) Section number - the lowest number shall be assigned to the oldest section and a basement, appraised as a separate section, immediately follows the section it is beneath;

(f) Occupancy code - nursing home or substructure;

(g) Average story height;

(h) Construction type;

(i) Number of stories;

(j) Gross floor area (which shall be the determination of the exterior dimensions of all interior areas including stairwells of each floor, specifically excluding outdoor patios, covered walkways, carports and similar areas). In addition, interior square footage measurements shall be reported for:

1. A non-NF area;

2. A shared service area by type of service; and

3. A revenue-generating area;

(k) Gross perimeter (common walls between sections shall be excluded from both sections);

(l) Construction quality;

(m) Year built;

(n) Building effective age;

(o) Building condition;

(p) Depreciation percent;

(q) Exterior wall material;

(r) Roof covering material and roof pitch;

(s) Heating system;

(t) Cooling system;

(u) Floor finish;

(v) Ceiling finish;

(w) Partition wall structure and finish;

(x) Passenger and freight elevators - actual number;

(y) Fire protection system (sprinklers, manual fire alarms, and automatic fire detection) - percent of gross area served. If both the floor and attic areas are protected by a sprinkler system or automatic detection, the percent of gross area served shall be twice the floor area; and

(z) Miscellaneous additional features which shall be limited to:

1. Canopies;

2. Entry foyers (sheltered entry ways): glass and aluminum standard allowance shall be twenty (20) dollars per square foot; bulkhead standard allowance shall be 5 (five) dollars per square foot;

3. Loading docks;

4. Bay windows, if not included in the perimeter calculation shall be valued at $1,500 each;

5. Code alerts, Wanderguards, or other special electronically-secured doorways (standard allowance shall be $1,500 for each fully-functioning door at the time of

appraisal);

6. Automatic sliding doors (standard allowance shall be $2,700 per doorway);

7. Detached garages or storage sheds (which shall have an attached reinforced concrete floor and a minimum of 200 square feet);

8. Modular buildings or trailers, if the structure has a minimum of 200 square feet, electrical service, and heating or cooling services (standard allowance shall be thirty-eight (38) dollars and fifty (50) cents per square foot);

9. Walk-in coolers or freezers;

10. Laundry chutes (standard allowance shall be $1,000 per floor serviced);

11. Dumb waiters (which shall have a minimum speed of fifty (50) feet per minute. The standard allowance shall be $4,500 for initial two (2) stops; $2,100 per additional stop);

12. Skylights (standard allowance shall be twenty-six (26) dollars per square foot);

13. Operable built-in oxygen delivery systems (valued at $250 per serviced bed); and

14. Carpeted wainscotting (standard allowance shall be three (3) dollars and fifty (50) cents per linear foot).

(4) An item listed in subsection (3)(z) of this section shall be subject to the Boeckh model #503 monetary limit unless a monetary limit is provided for that item.

(5) The department shall use the corresponding E.H. Boeckh System default value for any variable listed in subsection (3) of this section if no other value is stated for that variable in subsection (3) of this section.

(6) Values from the most recent E.H. Boeckh tables, as of July 1 of the year prior to the appraisal base year, shall be used during an appraisal. For example, values from

the most recent 1999 E.H. Boeckh tables, as of July 1, 1999, shall be used for an appraisal conducted during the appraisal period beginning January 1, 2000.

(7) In addition to an appraisal cited in subsection (1) of this section, the department shall appraise an NF identified in Section 2(1) of this administrative regulation if:

(a) The NF submits written proof of construction costs to the department; and

(b)1. The NF undergoes renovations or additions costing a minimum of $150,000 and the NF has more than sixty (60) licensed beds; or

2. The NF undergoes renovations or additions costing a minimum of $75,000 and the NF has sixty (60) or fewer licensed beds.

(8) An auxiliary building shall be:

(a) Appraised if it rests on land, as defined in Section 1(13) [~~1(14)~~] of this administrative regulation; and

(b) Appraised separately from an NF building.

(9) To appraise an auxiliary building, the department shall utilize an E.H. Boeckh building model other than the nursing home or convalescent center (#503) model, if the model better fits the auxiliary building's use and type.

(10) If an NF building has beds licensed for non-NF purposes, the appraisal shall be apportioned between NF and non-NF by dividing the number of licensed NF beds by the total number of beds, regardless of the occupancy factors.

(11) If, in an NF building, a provider conducts business activities not related to the NF, the appraisal shall be apportioned by the percent of NF square footage relative to the square footage of non-yNF-related business activities.

(12) Cost of an appraisal shall be the responsibility of the NF being appraised.

(13) A building held for investment, future expansion, or speculation shall not be considered for appraisal purposes.

(14) The department shall not consider the following location factors in rendering an appraisal:

(a) Climate;

(b) High-wind zone;

(c) Degree of slope;

(d) Position;

(e) Accessibility; or

(f) Soil condition.

Section 5. Standard Price Overview.

(1) Rates shall reflect the differential in wages, property values and cost of doing business in rural and urban designated areas.

(2) Effective October 31, 2003, The department shall utilize the Federal Office of Management and Budget's Metropolitan Statistical Area (MSA) urban and rural designations, in effect on January 1, 2003, to classify an NF as being in an urban or rural area.

(3) The department shall utilize an analysis of fair-market pricing and historical cost for the following data:

(a) Staffing ratios;

(b) Wage rates;

(c) Cost of administration, food, professional support, consultation, and nonpersonnel operating expenses as a percentage of total cost;

(d) Fringe benefit levels;

(e) Capital rate component; and

(f) Noncapital facility-related component.

(4) The following components shall comprise the case-mix adjustable portion of an NF's standard price:

(a) The personnel cost of:

1. A director of nursing;

2. A registered nurse (RN);

3. A licensed practical nurse (LPN);

4. A nurse aid;

5. An activities staff person; and

6. A medical records staff person; and

(b) Nonpersonnel operating cost including:

1. Medical supplies; and

2. Activity supplies.

(5) The following components shall comprise the noncase mix adjustable portion of an NF's standard price:

(a) Administration to include an allowance to offset a provider assessment;

(b) Nondirect care personnel;

(c) Food;

(d) Professional support; and

(e) Consultation.

(6) The following components shall comprise the facility and capital component of an

NF’s standard price:

(a) The noncapital facility-related component, which shall be a fixed, uniform amount for all price-based NF’s; and

(b) The NF’s capital rate component, which shall be facility specific.

(7) Excluding noncapital facility-related and capital rate components, the following is an example of an urban and a rural price-based NF's standard price based on re-based wages at the 2004 level:

MSA Designation	Case-Mix Adjustable Portion of Standard Price	Noncase-Mix Adjustable Portion of Standard Price Without Capital Cost Component	Total Standard Price Excluding Noncapital Facility Related and Capital Rate Components
Urban	$78.24 [61.83]	$58.84 [41.92]	$137.08 [103.75]
Rural	$64.58 [51.03]	$52.24 [36.53]	$116.82 [87.56]

(8) A price-based NF's standard price shall be adjusted for inflation every July 1. [~~:~~

~~(a) Established effective on January 1, 2000 representing the state fiscal year July 1, 1999 through June 30, 2000;~~

~~(b) Adjusted for inflation every July 1 by two and one-half (2.5) percent and the R.S. Means Construction Index; and~~

~~(c) Rebased every four (4) years thereafter.~~]

(9) An NF shall not receive a rate less than its standard price [~~An NF receiving a rate~~

~~less than its standard price shall have its rate adjusted for inflation on July 1 of each year pursuant to the DRI~~].

(10) The department shall adjust an NF's standard price if:

(a) A governmental entity imposes a mandatory minimum wage or staffing ratio increase and the increase was not included in the DRI; or

(b) A new licensure requirement or new interpretation of an existing requirement by the state survey agency results in changes that affect all facilities within the class. The provider shall document that a cost increase occurred as a result of a licensure requirement or policy interpretation.

Section 6. Standard Price Calculation.

(1) Based on the classification of urban or rural, the department shall calculate an individual NF's standard price to be the sum of:

(a) The case-mix adjustable portion of the NF's standard price, adjusted by the NF's current case-mix index pursuant to Section 7 of this administrative regulation;

(b) The noncase mix adjustable portion of the NF's standard price <u>which shall include an allowance to offset a provider assessment</u>;

(c) The noncapital facility-related component; and

(d) Pursuant to subsection (2) of this section, the capital rate component.

(2) An NF's capital rate component shall be calculated as follows:

(a) The department shall add the total of:

1. The NF's average licensed bed value which shall:

a. Be determined by dividing the NF's depreciated replacement cost, as determined from an appraisal conducted in accordance with Section 4 of this administrative

regulation, by the NF's total licensed NF beds; and

b. Not exceed $40,000;

2. A value for land which shall be ten (10) percent of the NF's average licensed NF bed value, established in accordance with subparagraph 1 of this paragraph; and

3. A value for equipment which shall be $2,000 per licensed NF bed;

(b) The department shall multiply the sum of paragraph (a) of this subsection by a rate of return factor which shall:

1. Be equal to the sum of:

a. The yield on a twenty (20) year treasury bond as of the first business day on or after May 31 of the most recent year; and

b. A risk factor of two (2) percent; and

2. Not be less than nine (9) percent nor exceed twelve (12) percent;

(c) The department shall determine the NF's capital cost-per-bed day by:

1. Dividing the NF's total patient days by the NF's available bed days to determine the NF's occupancy percentage;

2. If the NF's occupancy percentage is less than ninety (90) percent, multiplying ninety (90) percent by 365 days; and

3. If the NF's occupancy percentage exceeds ninety (90) percent, multiplying the NF's occupancy percentage by 365 days; and

(d) The department shall divide the sum of paragraphs (a) and (b) of this subsection by the NF's capital cost per bed day established in paragraph (c) of this subsection to determine an NF's capital rate component.

(3) [~~The department shall utilize the R.S. Means Construction Index to annually~~

~~adjust an NF's capital rate component.~~

~~(4)~~] If a change of ownership occurs pursuant to 42 C.F.R. 447.253(d), the new owner shall:

(a) Receive the capital cost rate of the previous owner unless the NF is eligible for a reappraisal pursuant to Section 4(7) of this administrative regulation; and

(b) File an updated provider application with the Medicaid Program pursuant to Section 3(4) of 907 KAR 1:672.

(4) [~~(5)~~] A new facility shall be:

(a) Classified as a new facility if the facility does not have a July 1, of the current state fiscal year, Medicaid rate;

(b) Determined to be urban or rural; and

(c) Reimbursed at its standard price which shall:

1. Be based on a case mix of 1.0;

2. Be adjusted prospectively based upon no less than one (1) complete calendar quarter of available MDS 2.0 data following the facility's Medicaid certification;

3. Utilize $40,000 as the facility's average licensed NF bed value until the facility is appraised in accordance with Section 4 of this administrative regulation; and

4. Be adjusted, if necessary, following the facility's appraisal if the appraisal determines the facility's average licensed NF bed value to be less than $40,000.

Section 7. Minimum Data Set (MDS) 2.0, Resource Utilization Group (RUG) III, and Validation.

(1) A price-based NF's Medicaid MDS data shall be utilized to determine its case mix index each quarter.

(2) A price-based NF's case mix index shall be applied to its case mix adjustable portion of its standard price.

(3) To determine a price-based NF's case mix index, the department shall:

(a) Extract the required MDS data from the NF's MDS form:

1. Incorporated by reference in 907 KAR 1:755;

2. Transmitted by the NF to the Cabinet for Health and Family Services, Office of Inspector General, Division of Long Term Care; and

3. On the last date of each calendar quarter and revised no later than the data revision cut-off date established in subsection (7)(b) of this section;

(b) Classify the data cited in paragraph (a) of this subsection through the RUG III, (M3 p1), version five point twelve B (5.12B) thirty-four (34) group model resident classification system; and

(c) Validate the data cited in paragraph (a) of this subsection as follows:

1. The department shall generate a random sample of twenty-five (25) percent of the price-based NF's Medicaid MDS assessments;

2. The department shall review medical records corresponding to the individuals included in the sample identified in subparagraph 1 of this paragraph to determine if the medical records accurately support the MDS assessments submitted for the sample residents; and

3. If a review of records cited in subparagraph 2 of this paragraph reveals that the price-based NF fails to meet the minimum accuracy threshold, the department shall review 100 percent of the price-based NF's Medicaid MDS assessments extracted in accordance with paragraph (a)3 of this subsection to determine whether the NF fails to

meet the minimum accuracy threshold.

(4) If the department's review, in accordance with subsections (3)(c)2 and 3 of this section, of a price-based NF's MDS assessment data reveals that the NF fails to meet the MDS data minimum accuracy threshold, the department shall conduct another review of the same data utilizing an individual or individuals not involved in the initial validation process if the price-based NF requests a re-review within ten (10) business days of being notified of the findings of the review cited in subsection (3)(c)3 of this section.

(5) Only MDS data extracted in accordance with subsection (3)(a)3 of this section shall be allowed during a review or re-review.

(6) If a re-review of a price-based NF's MDS assessment data, in accordance with subsection (4) of this section, confirms that the NF fails to meet the minimum accuracy threshold, the department shall:

(a) Conduct a conference with the NF to review preliminary findings of the re-review; and

(b) Send the final results of the re-review to the NF within ten (10) business days of the conference.

(7) Following is a chart establishing:

(a) That an MDS extraction date shall be the last date of each quarter;

(b) That a final MDS assessment data revision cut-off date shall be the last date of the quarter following the date on which MDS data was extracted. For example, MDS data or revisions to MDS data extracted December 31, 2000 shall not be accepted after March 31, 2001;

(c) That a rate effective date shall be the first date of the second quarter following the MDS extraction date;

(d) That MDS audits shall be initiated in the same month containing the corresponding rate effective date;

(e) MDS assessment accuracy thresholds and corresponding rate sanctions. For example if a price-based NF's percentage of accurate MDS assessments is below fifty (50) percent for MDS data extracted March 31, 2002, then effective October 1, 2002, the price-based NF's rate shall be sanctioned by fifteen (15) cents per patient day; and

(f) Rate sanction effective dates:

MDS Data Extraction Date	MDS Data Revision Cut-Off Date	Rate Effective Date	Audits Initiated	Required MDS Accuracy Threshold	Rate Sanction	Sanction Effective Date
6/30/01	9/30/01	10/1/01	10/2001	40%	$0.10 per patient day (ppd)	1/1/02
9/30/01	12/31/01	1/1/02	1/2002	40%	$0.10 ppd	4/1/02
12/31/01	3/31/02	4/1/02	4/2002	50%	$0.15 ppd	7/1/02
3/31/02	6/30/02	7/1/02	7/2002	50%	$0.15 ppd	10/1/02
6/30/02	9/30/02	10/1/02	10/2002	65%	$0.20 ppd	1/1/03
9/30/02	12/31/02	1/1/03	1/2003	65%	$0.20 ppd	4/1/03
12/31/02 and forward	3/31/02 and	4/1/03 and forward	4/2003 and	65-79% 40-64%	$0.50 ppd $0.60 ppd	7/1/03 and

	forward		forward	Below 40%	$0.70 ppd	forward

Section 8. Limitation on Charges to Residents.

(1) Except for applicable deductible and coinsurance amounts, an NF that receives reimbursement for a resident pursuant to Section 6 of this administrative regulation shall not charge a resident or his representative for the cost of routine or ancillary services.

(2) An NF may charge a resident or his representative for an item pursuant to 42 C.F.R. 483.10 (c)(8)(ii) if:

(a) The item is requested by the resident;

(b) The NF informs the resident in writing that there will be a charge; and

(c) Medicare, Medicaid, or another third party does not pay for the item.

(3) An NF shall:

(a) Not require a resident, or responsible representative of the resident, to request any item or services as a condition of admission or continued stay; and

(b) Inform a resident, or responsible representative of the resident, requesting an item or service for which a charge will be made in writing that there will be a charge and the amount of the charge.

(4) Reserved bed days, per resident, for an NF or an NF-W shall be covered for a maximum of:

(a) Fourteen (14) days per temporary absence due to hospitalization, with an overall maximum of forty-five (45) days during a calendar year; and

(b) Fifteen (15) days during a calendar year for leaves of absence other than hospitalization.

(5) Except for oxygen therapy, durable medical equipment (DME) and supplies shall:

(a) Be furnished by an NF; and

(b) Not be billed to the department under a separate DMS claim pursuant to 907 KAR 1:479, Section 6(3).

Section 9. Reimbursement for Required Services Under the Preadmission Screening Resident Review (PASRR).

(1) Prior to an admission of an individual, a price-based NF shall conduct a level I PASRR in accordance with 907 KAR 1:755, Section 4.

(2) The department shall reimburse an NF for services delivered to an individual if the NF complies with the requirements of 907 KAR 1:755.

(3) Failure to comply with 907 KAR 1:755 may be grounds for termination of the NF's participation in the Medicaid Program.

Section 10. Price-Based NF Protection Period and Budget Constraints.

(1) Effective January 1, 2003, a county-owned hospital-based nursing facility shall not receive a rate that is less than the rate that was in effect on June 30, 2002.

(2) For each year of the biennium, a price-based NF shall:

(a) Receive an increase pursuant to Section 5(8) [~~and (9)~~] of this administrative regulation; or

(b) Except for a county-owned hospital-based nursing facility pursuant to subsection (1) of this section, not receive an increase if the price-based NF's rate is greater than its standard price.

[~~(3) Available price-based nursing facility funds shall be used to increase rates for facilities whose rates are less than their standard price.~~

~~(a) A facility receiving an increase shall receive an increase equal to a percentage of the difference between its existing rate and its standard price.~~

~~(b) The percentage shall be the same for each applicable facility.~~

~~(4) Available funds under this section shall be funds appropriated in a biennium budget less:~~

~~(a) Any reduction due to a programmatic change that affects nursing facility reimbursement; or~~

~~(b) Any reduction in the department's budget that affects nursing facility reimbursement.~~]

Section 11. Cost Report.

(1) A Medicare cost report and the Supplemental Medicaid Schedules shall be submitted pursuant to time frames established in the HCFA Provider Reimbursement Manual - Part 2 (Pub. 15-11) Section 102, 102.1, 102.3, and 104, incorporated by reference into this administrative regulation; and

(2) A copy of a price-based NF's Medicare cost report shall be submitted for the most recent fiscal year end.

Section 12. Ancillary Services.

[~~(1)~~] Effective November 1, 2003:

(1) [~~(a)~~] Except for oxygen therapy, the department shall reimburse for an ancillary service that meets the criteria established in 907 KAR 1:023 utilizing the corresponding outpatient procedure code rate listed in the Medicaid Physician Fee Schedule established in 907 KAR 3:010, Section 3;

(2) [~~(b)~~] The department shall reimburse for an oxygen therapy utilizing the Medicaid

DME Program fee schedule established in 907 KAR 1:479; and

(3) [~~(c)~~] Respiratory therapy and respiratory therapy supplies shall be a routine service. [~~;~~

~~(d) The department shall calculate an add-on amount, to be in effect from November 1, 2003 through June 30, 2004, to a nursing facility's routine services per diem rate if the nursing facility incurred cost providing respiratory therapy or respiratory therapy supplies for the period July 1, 2003 through September 30, 2003; and~~

~~(e) The add-on referenced in paragraph (d) of this subsection shall be equal to a nursing facility's annualized Medicaid-allowed cost of respiratory therapy and respiratory supplies for the period July 1, 2003 through September 30, 2003 divided by the nursing facility's Medicaid days reported on the most recent cost report filed with the department as of November 1, 2003~~.

~~(2) A nursing facility shall apply for a routine services per diem add-on referenced in subsection (1)(d) of this section by submitting a Schedule J Request for Reimbursement form to the department by December 1, 2003.~~

~~Section 13. Reimbursement for State Fiscal Years (SFY) 2003 and 2004 (July 1, 2002 through June 30, 2004).~~

~~(1) The department shall not make an adjustment to a provider's rate using available funds as described in Section 10(4) of this administrative regulation except:~~

~~(a) For an adjustment resulting from a provider's case mix index established in accordance with Section 7 of this administrative regulation; or~~

~~(b) For funds realized through the ancillary reimbursement provisions established in Section 12(1) of this administrative regulation.~~

~~(2) The department shall make a supplemental payment in accordance with Section 15 of this administrative regulation.~~

~~(3) The department shall make adjustments to a provider's rate in accordance with subsections (4), (5), (6) and (7) of this section, and Section 10(1) of this administrative regulation subject to the availability of funds. Available funds under this subsection shall be:~~

~~(a) An amount during the expenditure period equal to fifty (50) percent of the payments received during the revenue period by nursing facilities under Section 15(3) of this administrative regulation after deducting the nonfederal share of the funds, less the funds retained by a facility required to bring its Medicaid rate to its standard price; and~~

~~(b) Matched with federal funds.~~

~~(4) Payments under subsection (3) of this section shall be distributed during the expenditure period.~~

~~(5) An inflationary adjustment of two and one-half (2.5) percent shall be made to the operating component of a provider's rate.~~

~~(6) An inflationary adjustment equal to the R.S. Means Construction Index shall be made to the capital component of a provider's rate.~~

~~(7) An NF receiving less than its standard price shall have its rate adjusted in accordance with Sections 5(9) and 10(3) of this administrative regulation.~~]

Section 13. [~~14.~~] Appeal Rights. A price-based NF may appeal a department decision as to the application of this administrative regulation in accordance with 907 KAR 1:671.

Section 14 [~~15~~]. Supplemental Payments to Nonstate Government-Owned or

Operated Nursing Facilities.

(1) Beginning July 1, 2001, subject to state funding made available for this provision by a transfer of funds from a governmental entity, the department shall make a supplemental payment to a qualified nursing facility.

(2) To qualify for a supplemental payment under this section, a nursing facility shall:

(a) Be owned or operated by a local unit of government pursuant to 42 C.F.R. 447.272(a)(2);

(b) Have at least 140 or more Medicaid-certified beds; and

(c) Have a Medicaid occupancy rate at or above seventy-five (75) percent.

(3) For each state fiscal year, the department shall calculate the maximum supplemental payment that it may make to qualifying nursing facilities in accordance with 42 C.F.R. 447.272.

(4) Using the data reported by a nursing facility on a Schedule NF-7 submitted to the department as of December 31, 2000, the department shall identify each nursing facility that meets the criteria established in subsection (2) of this section.

(5) The department shall determine a supplemental payment factor for a qualifying nursing facility by dividing the qualifying nursing facility's total Medicaid days by the total Medicaid days for all qualifying nursing facilities.

(6) The department shall determine a supplemental payment for a qualifying nursing facility by applying the supplemental payment factor established in subsection (5) of this section to the total amount available for funding under this section.

(7) Total payments made under this section shall not exceed the amount determined in subsection (3) of this section.

(8) Payments made under this section shall:

(a) Apply to services provided on or after April 1, 2001; and

(b) Be made on a quarterly basis.

Section 15 [~~16~~]. Incorporation by Reference.

(1) The following material is incorporated by reference:

(a) "Medicare Provider Reimbursement Manual - Part 2 (Pub. 15-11) Chapter 1. Cost Reporting - General (15-2-102) 102 and 104. Cost Reporting Period; April 2000 Edition";

(b) The "Instructions for Completing the Medicaid Supplemental Schedules, November 2003 Edition";

(c) The "Supplemental Medicaid Schedules, November 2003 Edition"; and

(d) The "Schedule J Request for Reimbursement, November 2003 Edition.

(2) This material may be inspected, copied, or obtained, subject to applicable copyright law, at the Department for Medicaid Services, 275 East Main Street, Frankfort, Kentucky 40621, Monday through Friday, 8 a.m. to 4:30 p.m.

Date

Russ Fendley, Commissioner
Department for Medicaid Services

Date

Dr. Duane Kilty
Undersecretary for Administration and Fiscal Affairs

Date

James. W. Holsinger, Jr., MD, Secretary
Cabinet for Health and Family Services

REGULATORY IMPACT ANALYSIS
AND TIERING STATEMENT

Administrative Regulation #: 907 KAR 1:065E
Cabinet for Health Services
Department for Medicaid Services
Agency Contact Person: Teresa Goodrich or Stuart Owen (564-6204)

(1) Provide a brief summary of:
(a) What this administrative regulation does: This administrative regulation establishes the Department for Medicaid Services (DMS) reimbursement methodology for price based nursing facility services.
(b) The necessity of this administrative regulation: This administrative regulation is necessary to establish DMS reimbursement methodology for price based nursing facility services.
(c) How this administrative regulation conforms to the content of the authorizing statutes: This administrative regulation conforms to the authorizing statutes by establishing DMS reimbursement methodology for price based nursing facility services.
(d) How this administrative regulation currently assists or will assist in the effective administration of the statutes: This administrative regulation will assist in the effective administration of the authorizing statutes by establishing DMS reimbursement methodology for price based nursing facility services.

(2) If this is an amendment to an existing administrative regulation, provide a brief summary of:
(a) How the amendment will change this existing administrative regulation: The amendment to this administrative regulation increases price-based nursing facility service reimbursement to offset a provider assessment in accordance with HB 292 of the 2004 Session of the General Assembly.
(b) The necessity of the amendment to this administrative regulation: The amendment is necessary to comply with HB 292 of the 2004 Session of the General Assembly.
(c) How the amendment conforms to the content of the authorizing statutes: HB 292 of the 2004 Session of the General Assembly authorizes DMS to increase provider reimbursement to offset a provider assessment.
(d) How the amendment will assist in the effective administration of the statutes: The amendment will assist DMS in the effective administration of the authorizing statutes by increasing price-based nursing facility service reimbursement to offset a provider assessment in accordance with HB 292 of the 2004 Session of the General Assembly.

(3) List the type and number of individuals, businesses, organizations, or state and local government affected by this administrative regulation: There are approximately 279 price based nursing facilities currently participating in the Medicaid program.

(4) Provide an assessment of how the above group or groups will be impacted by either the implementation of this administrative regulation, if new, or by the change if it is an amendment: Providers will receive an increase in reimbursement to offset a provider assessment in accordance with HB 292 of the 2004 Session of the General Assembly.

(5) Provide an estimate of how much it will cost to implement this administrative regulation:
(a) Initially: The amendment to his administrative regulation is estimated to cost approximately $44 million annually ($13.2 million state funds; $30.8 million federal funds) with state funding provided by the Medical Assistance Revolving Trust (MART) Fund in accordance with HB 292 of the 2004 Session of the General Assembly.
(b) On a continuing basis: The amendment to his administrative regulation is estimated to cost approximately $44 million annually ($13.2 million state funds; $30.8 million federal funds) with state funding provided by the Medical Assistance Revolving Trust (MART) Fund in accordance with HB 292 of the 2004 Session of the General Assembly.

(6) What is the source of the funding to be used for the implementation and enforcement of this administrative regulation: Funding to implement the amendment to this administrative regulation will be provided by the MART Fund in accordance with HB 292 of the 2004 Session of the General Assembly.

(7) Provide an assessment of whether an increase in fees or funding will be necessary to implement this administrative regulation, if new, or by the change if it is an amendment: No increase in fees will be necessary to implement the amendment to his administrative regulation and funding will be provided by the MART Fund in accordance with HB 292 of the 2004 Session of the General Assembly.

(8) State whether or not this administrative regulation establishes any fees or directly or indirectly increases any fees: This administrative regulation does not establish any fees nor directly or indirectly increase any fees.

(9) Tiering: Is tiering applied? (Explain why tiering was or was not used)
Tiering was not appropriate in this administrative regulation because the administrative regulation applies equally to all those individuals or entities regulated by it. Disparate treatment of any person or entity subject to this administrative regulation could raise questions of arbitrary action on the part of the agency. The “equal protection” and “due process” clauses of the Fourteenth Amendment of the U.S. Constitution may be implicated as well as Sections 2 and 3 of the Kentucky Constitution.

FEDERAL MANDATE ANALYSIS COMPARISON

Regulation Number: 907 KAR 1:065E

Agency Contact: Stuart Owen or Teresa Goodrich (564-6204)

1. Federal statute or regulation constituting the federal mandate.

   Pursuant to 42 USC 1396a et. seq., the Commonwealth of Kentucky has exercised the option to establish a Medicaid Program for indigent Kentuckians. Having elected to offer Medicaid coverage, the state must comply with federal requirements contained in 42 USC 1396 et. seq.

2. State compliance standards.

   The amendment to this administrative regulation increases provider reimbursement in order to offset a provider assessment in accordance with HB 292 of the 2004 Session of the General Assembly.

3. Minimum or uniform standards contained in the federal mandate.

   This administrative regulation does not set minimum or uniform standards related to a federal mandate.

4. Will this administrative regulation impose stricter requirements, or additional or different responsibilities or requirements, than those required by the federal mandate?

   This administrative regulation does not set stricter requirements.

5. Justification for the imposition of the stricter standard, or additional or different responsibilities or requirements.

   No additional standard or responsibilities are imposed.